


# AGS Position Statement: Resource Allocation Strategies and Age-Related Considerations in the COVID-19 Era and Beyond

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Coronavirus disease 2019 (COVID-19) continues to impact older adults disproportionately, from severe illness and hospitalization to increased mortality risk. Concurrently, concerns about potential shortages of healthcare professionals and health supplies to address these needs have focused attention on how resources are ultimately allocated and used. Some strategies misguidedly use age as an arbitrary criterion, inappropriately disfavoring older adults. This statement represents the official policy position of the American Geriatrics Society (AGS). It is intended to inform stakeholders including hospitals, health systems, and policymakers about ethical considerations to consider when developing strategies for allocating scarce resources during an emergency involving older adults. Members of the AGS Ethics Committee collaborated with interprofessional experts in ethics, law, nursing, and medicine

(including geriatrics, palliative care, emergency medicine, and pulmonology/critical care) to conduct a structured literature review and examine relevant reports. The resulting recommendations defend a particular view of distributive justice that maximizes relevant clinical factors and deemphasizes or eliminates factors placing arbitrary, disproportionate weight on advanced age. The AGS positions include (1) avoiding age per se as a means for excluding anyone from care; (2) assessing comorbidities and considering the disparate impact of social determinants of health; (3) encouraging decision makers to focus primarily on potential short-term (not long-term) outcomes; (4) avoiding ancillary criteria such as “life-years saved” and “long-term predicted life expectancy” that might disadvantage older people; (5) forming and staffing triage committees tasked with allocating scarce resources; (6) developing institutional resource allocation strategies that are transparent

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and applied uniformly; and (7) facilitating appropriate advance care planning. The statement includes recommendations that should be immediately implemented to address resource allocation strategies during COVID-19, aligning with AGS positions. The statement also includes recommendations for post-pandemic review. Such review would support revised strategies to ensure that governments and institutions have equitable emergency resource allocation strategies, avoid future discriminatory language and practice, and have appropriate guidance to develop national frameworks for emergent resource allocation decisions. *J Am Geriatr Soc* 68:1136-1142, 2020.

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Older adults are disproportionately affected by the coronavirus disease 2019 (COVID-19) pandemic's devastating consequences of severe illness, hospitalization, and death. The extent to which this disproportionate impact is due to factors such as the disease itself, versus the response of healthcare systems to the disease, is unknown. Concerns about potential shortages of ventilators, intensive care unit beds, and hospital beds, both now and in the fall when resource shortages caused by any surge in COVID-19 will likely be intensified due to influenza, have focused attention on how decisions to allocate these scarce resources are being made.

Many of the initially available resource allocation strategies were informed by the H1N1 pandemic more than 10 years ago. The first resource allocation strategy specific to COVID-19 was developed in northern Italy,<sup>1,2</sup> where the number of people with this illness far exceeded available resources. Since then, several frameworks have been put forward that address rationing of scarce resources in times of crisis.<sup>3-5</sup> However, some strategies adopted by states and professional societies apply age as a criterion in a way that disproportionately disfavors older adults, such as categorical exclusions based on advanced age,<sup>6,7</sup> raising concerns that older adults may be treated unjustly when there is an emergent need to ration resources due to a crisis such as the COVID-19 pandemic.

## OVERALL FRAMING

We developed this American Geriatrics Society (AGS) position statement and the companion manuscript, "Rationing Limited Health Care Resources in the COVID-19 Era and Beyond: Ethical Considerations Regarding Older Adults,"<sup>8</sup> within the context of a society in which too few adults have engaged in meaningful advance care planning discussions with their families and loved ones, and, as a result, they have not completed an advance directive.<sup>9</sup> We also considered the overall framework of a just society with a specific focus on healthcare systems and reviewed legal considerations. We determined that it is important to include these

considerations in both this AGS position statement and in the companion manuscript.

## Urgent Need for Advance Care Planning

The COVID-19 pandemic further highlights the widespread and urgent need for all adults to engage in advance care planning discussions and create an advance directive. Advance care planning discussions are of paramount importance to reduce the need to ration limited healthcare resources during an emergency because these discussions will identify people who do not wish to receive intensive care including mechanical ventilation. A critical point in the discussion of advance care planning is that these discussions are not rationing and should not be confused with triage allocation decisions. Advance care planning discussions should occur before patients are in crisis and should be part of every patient's individualized care plan.<sup>10,11</sup> A conversation with older patients about what matters most to them<sup>12</sup> and their goals of care should not lead healthcare providers to infer incorrectly that simply having had a goals of care discussion signals a clear preference for limited interventions. Also, providers should be aware that care plans developed for anticipated longer term declines in health may not be applicable to sudden emergencies such as COVID-19, and it is inappropriate to infer from a do not resuscitate (DNR) order that a particular patient would necessarily refuse mechanical ventilation.<sup>13</sup>

## Achieving Justice in Resource Allocation

A just healthcare system should treat similarly situated people equally, as much as possible.<sup>14-16</sup> There is something particularly unjust about membership in a class, such as an age group, determining whether a person receives health care. Not only is membership in a class defined by characteristics such as race, sex, or age, beyond the individual's control, but the use of these criteria might conceal implicit biases and other social inequities. Because health care is critically important to many other goods in life across the life span, it may be distinct in terms of requiring equal access. These factors suggest that basing resource allocation decisions on advanced age may violate the ethical principle of justice.

Resource allocation strategies, such as those proposed in response to COVID-19, rely on different notions of distributive justice. There are many contested theories, and each theory claims to represent justice in the priority given certain factors or values when goods are distributed to society. This position statement defends a view of distributive justice that maximizes relevant clinical factors and either deemphasizes or eliminates factors that place an arbitrary and disproportionate weight on advanced age.

## Legal Considerations

The nondiscrimination section of the Affordable Care Act, § 1557, prohibits discrimination in federally funded healthcare programs on the grounds prohibited by the Age Discrimination Act of 1975, 42 U.S.C. §§ 6101-6107. The Age Discrimination Act applies to discrimination on the basis of age that includes exclusion from, participation

in, or denial of the benefits of, any program or activity receiving federal financial assistance. Allocation frameworks that use age as a categorical exclusion violate this provision of federal antidiscrimination law. Whether provisions of the Age Discrimination Act beyond identifying age as a category are also included by reference in § 1557 is an unsettled legal question, but if they are, they would permit age to be used as a proxy for some other characteristic, such as survivability, that is necessary to the statutory objective or to the business and that cannot practically be measured in an individualized way. The statute and implementing regulations would also permit use of reasonable factors other than age that have a disproportionate effect on persons of different ages, if the factor bears a direct and substantial relationship to the program's normal operation or statutory objective.<sup>17</sup> The legal question then would be whether factors such as long-term survival or life-years lived are reasonable factors other than age that meet this standard.

## METHODS

The AGS Ethics Committee is charged with ensuring that every older American receives high-quality person-centered care by improving public and professional understanding of ethical and moral issues intrinsic in caring for older adults. The committee developed these policy and clinical recommendations in collaboration with an interprofessional writing team of experts in ethics, law, nursing, and medicine (including geriatrics, palliative care, emergency medicine, and pulmonology/critical care). This team conducted a structured literature review and examined relevant reports and studies that are outlined in the companion article.<sup>8</sup>

## ABOUT THIS POSITION STATEMENT

This statement represents the official policy position of the AGS. It is intended to inform stakeholders including hospitals, health systems, and policymakers about ethical considerations involving older adults that should be considered when developing strategies for allocation of scarce resources during an emergency. The rationale for each position is provided in a companion article,<sup>8</sup> and the rationale for immediate implementation strategies is included in this position statement. Members of the AGS Ethics Committee led the writing group, and the AGS Executive, Ethics, Ethnogeriatrics, and Clinical Practice and Models of Care Committees provided review and input. The statement was approved by the AGS Ethics and AGS Executive Committees (on behalf of the AGS board) in April 2020. It will be reviewed and updated (if needed) in 2025.

The AGS is a nationwide not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our more than 6,000 members are geriatricians, geriatric nurses, nurse practitioners, social workers, family physicians, physician assistants, pharmacists, internists, and specialty physicians who are pioneers in advanced-illness care for older individuals.

## AGS RECOMMENDATIONS FOR RESOURCE ALLOCATION STRATEGIES IF EMERGENCY RATIONING IS REQUIRED

These recommendations were developed to guide hospitals, health systems, and policymakers in their efforts to develop emergency rationing strategies. Our recommendations are informed by a structured literature review and a discussion of a number of issues that are described more fully in our companion article. These issues include (1) age as a determining factor, (2) age as a tiebreaker, (3) criteria with a differential impact on older adults, (4) individual choices and advance directives, (5) racial/ethnic disparities and resource allocation, (6) scoring systems and their impact on older adults, and (7) the need for post-pandemic review.<sup>8</sup>

1. Age per se should never be used as a means for a categorical exclusion from therapeutic interventions that represent the standard of care. Likewise, specific age-based cutoffs should not be used in resource allocation strategies.
2. When assessing comorbidities, the disparate impact of social determinants of health including culture, ethnicity, socioeconomic status, and other factors should be considered.
3. Multifactor resource allocation strategies that equally weigh in-hospital survival and severe comorbidities contributing to short-term (<6 months) mortality should be the primary allocation method in emergency circumstances that require rationing due to a lack of resources.
4. To avoid biased resource allocation strategies, criteria such as "life-years saved" and "long-term predicted life expectancy" should not be used because they disadvantage older adults.
5. Triage committees and triage officers who have no direct clinical role in the care of the patients being considered for allocation of limited resources should be familiar with resources available at their institution and also should be available to clinicians when decisions about allocating scarce resources must be made. Whenever possible, these committees should include persons with expertise in the disciplines of ethics, geriatrics, and palliative care.
6. Institutions should develop resource allocation strategies that are transparent, applied uniformly, and developed with forethought and input from the multiple disciplines of ethics, medicine, law, and nursing. These strategies should be used consistently when making emergency decisions. Such strategies should be reviewed frequently to ensure inclusion of the latest science and to identify any evidence of disparate impact or bias.
7. Widespread and carefully considered advance care planning discussions are of paramount importance in achieving ethical care decisions based on the individual's values, preferences, and goals. These decisions should not be viewed as a form of rationing, and advance care planning should preferably be done well before a time of crisis. Efforts should be intensified to increase meaningful advance care planning across health systems.

## AGS RECOMMENDED STRATEGIES FOR IMMEDIATE IMPLEMENTATION DURING THE COVID-19 PANDEMIC

Given the current and near-future implications of the COVID-19 pandemic, the AGS recommends the following strategies for immediate implementation. Given the urgent need to implement these strategies, we have included our rationale for each.

### Implementing a Multifactor Resource Allocation Strategy

We recommend that institutions implement a multifactor resource allocation strategy as the primary allocation method that equally weighs in-hospital survival and comorbidities contributing to short-term mortality (<6 months), rather than implementing a resource allocation strategy based primarily on life-cycle principles. Age should never be used as a categorical exclusion; this violates the principle of justice and discriminates against older adults. Moreover, a robust body of literature demonstrates that chronological age alone is less predictive of mortality than other factors such as functional trajectory,<sup>18</sup> multimorbidity,<sup>19,20</sup> and frailty.<sup>21,22</sup> Thus age is a poor proxy for projected outcomes. Moreover, as discussed later, including chronic comorbidities unlikely to affect survival or 6-month mortality is ethically problematic. We recommend including only severe comorbidities likely to result in death over a short period of time, such as less than 6 months.

It is important to note that reliance on in-hospital survival as a strategy is not at odds with policies at many institutions that withhold care that offers no possibility of clinical benefit. The withholding of such futile care, although reducing resource use, is justified by the principle of beneficence that applies to persons of all ages.

### Establishing Triage Committees and Identifying Triage Officers

In the event that resources are so constrained that emergency rationing must occur, and for circumstances in which consideration is given to withdrawing resources due to medical futility, triage committees and triage officers should be established and available around the clock to implement rationing strategies. These third parties, who are not members of the primary care team, could integrate objective considerations about decision making with rationing. Early initiation of these roles would alleviate moral distress among front-line clinicians. Being able to rely on a pre-existing rationing strategy allows them to focus on clinical care. Clinicians at the front lines should be applying, not selecting, emergency rationing criteria when resources are limited. In addition, transparent criteria developed by triage committees and triage officers can be reviewed systematically for their potential to cause differential impact on underrepresented groups.

### Clear Communication About Available Resources

States and health systems should communicate clearly and transparently about the ethical resource allocation strategies

that are proposed and selected. Transparent communication is crucial in promoting greater adherence to these strategies. A clear description of legal and ethical accountability and responsibility regarding these policies is also needed. During the COVID-19 pandemic when information is changing rapidly, policies and chosen strategies should come from a centralized source for direct communication to healthcare providers and clinicians.

### Individual Care Plans

All older adults should be encouraged to develop individual care plans<sup>24</sup> that include information such as lists of medical conditions, medications, and healthcare providers, as well as advance directives. The Medicare Annual Wellness Visit is an ideal setting for healthcare providers to establish and update these individual care plans with patients and their caregivers.

### Advance Care Planning During and After the COVID-19 Pandemic

Advance care planning must be prioritized both now and after COVID-19. The rate of advance directive completion is unacceptably low at about 50% of adults aged 60 years and older.<sup>9</sup> Medicare reimbursement for advance care planning discussions presents opportunities to increase advance directive completion. Completion of advance directives is necessary but insufficient. There must also be a meaningful goals of care discussion focusing on what matters most to the patient and also ensuring patient understanding by accounting for cultural factors, limited health literacy, and sensory deficits that may impede communication.

Advance care planning should not be limited to the purview of only the primary care, geriatrics, or palliative care health professional, and urgent efforts should be made to discuss patient preferences before an emergent need arises. All outpatient clinicians including subspecialists, and particularly those who care for high-risk populations such as pulmonologists, cardiologists, rheumatologists, nephrologists, and transplant specialists, should engage in this advance care planning effort. In fact, many of these specialists are best suited to assess their patient's chronic illness, such as the severity of a patient's chronic lung disease and likelihood of survival through critical illness, to guide decision making.

Patients are grappling with the new realities of care with the rise in virtual care modalities and are looking to all providers to give them an individualized risk assessment should they become ill with COVID-19. These conversations are opportunities to discuss advance care planning, but providers should not pressure patients, even subtly, to engage in advance care planning or change to do not resuscitate/do not (DNR/DNR) intubate status with the intent to conserve healthcare resources. The existence of a prior advance directive should be confirmed with the patient, healthcare proxy, or surrogate decision maker before medical decisions are made. The most basic discussion should include a decision about a surrogate decision maker, and more advanced conversations should include patient preferences about mechanical ventilation and, if sought, the

clinician's assessment of the patient's comorbidities and likelihood of survival following critical illness.<sup>10,25</sup>

Advance care planning discussions should be documented appropriately and clearly with reliable contact information for surrogate decision makers. Although less ideal, such discussions can also occur in the emergency department (ED) setting. Goals of care discussions should not attempt to dissuade patients from using a ventilator or focus on resource allocation generally, but rather should attempt to elicit what matters most to the patient<sup>26</sup> to help healthcare providers understand the individual and their progression through health and illness. Advance care planning for older adults should be facilitated in all settings through enhanced means of communication including telephone visits and virtual care modalities such as telehealth visits where needed.

The shifting of outpatient care delivery (e.g., to telephone and virtual encounters) should include intensive outreach efforts to identify highly vulnerable patients (e.g., living alone, cognitively impaired) at high risk from the detrimental effects of social isolation and who, in the absence of intensive telephone or virtual outreach, would otherwise be less likely to engage in advance care planning.

In many cases, critical advance care planning discussions may need to be conducted with a surrogate who cannot be with the patient due to physical distancing (commonly referred to as social distancing) or facility visitation restrictions. These conversations can be appropriately performed as audio-only services. The Centers for Medicare & Medicaid Services approved payment for advance care planning that is provided via audio (telephone only), and should extend changes to telehealth payment beyond the current emergency so that reimbursement is equivalent to in-person provision of advance care planning given the time-intensive nature of these discussions.

### Ensuring Access to Hospice and Palliative Care

The AGS recommends enhancing the availability of hospice and palliative care within post-acute facilities, long-term care, and assisted living facilities and removing barriers to obtaining palliative care and hospice care in these settings.<sup>23</sup> For those individuals who are (1) critically ill but elect against high-intensity treatment measures, or (2) are unlikely to benefit from critical care, or (3) when it is compellingly clear that health resources are limited and rationing decisions are in adherence with institutional policies, supportive care services should be invested in as part of COVID-19 surge preparations in acute care settings such as emergency departments.

### CALL FOR POST-PANDEMIC REVIEW OF COVID-19 RATIONING STRATEGIES FOR OLDER ADULTS: AGS RECOMMENDATIONS

The AGS is deeply concerned about potentially negative long-term consequences of COVID-19 emergency rationing strategies that disfavor older adults. In particular, rationing strategies that are solely, or predominantly, based on age cutoffs could lead to persistent beliefs that older adults' lives are less valuable than others' lives or are even expendable, and contribute to already rampant ageism.<sup>27</sup> Unless

the injustice in these strategies is corrected, this will be a persistent issue if there is a resurgence of COVID-19 cases, a pandemic caused by a different virus in the future, or a different type of disaster where resources are scarce. Also, given that ageist views<sup>12</sup> existed before the COVID-19 pandemic, including in the media and in hiring practices, it is not difficult to imagine that ageism would be further amplified by problematic COVID-19 rationing strategies. In light of these concerns, the AGS believes that there should be a post-pandemic review focused on removing discriminatory language from resource allocation strategies created during the pandemic, and on developing and implementing ethical resource allocation strategies to be used when emergency rationing is required.

### Recommendations

1. State and local governments and institutions should establish committees that include older adults to conduct a post-pandemic review of outcomes of emergency rationing strategies that were actually implemented. This review process should be conducted using deidentified data and include results such as survival rates stratified by age group and comorbidities, with the goal of informing the development of a national framework that can guide institutions in developing decision-making strategies for resource allocation that are just and equitable.
2. Hospital ethics committees, state officials, and other relevant stakeholders should remove discriminatory provisions including age-based cutoffs that disfavor older adults from any resource allocation strategies including those that were developed during the COVID-19 pandemic.
3. Healthcare facilities and systems that did not develop or do not currently have a resource allocation strategy should develop an ethical framework or adopt an existing ethical framework that incorporates the principles described in this AGS position statement.

### SUMMARY

Emergency resource allocation strategies during the era of COVID-19 and during future pandemics must not disproportionately disfavor older adults. Ideally, these strategies will be developed and integrated into institutional policies when an institution is not in crisis. When developing and implementing such strategies, key stakeholders including ethics committees, healthcare systems, and policymakers must not apply categorical age exclusions because such exclusions are unethical and violate antidiscrimination law. Ethical multifactor resource allocation strategies exist that rely on in-hospital survival and severe comorbidities contributing to short-term (<6 months) mortality. Extreme care must be taken to consider the disparate impact on older adults of assessing comorbidities as part of resource allocation strategies because older adults are heterogeneous with respect to burden of comorbidities and functional status. Racial and ethnic minorities are at even greater risk of the disparate impacts of assessing comorbidities in resource allocation strategies.

Moreover, our understanding of COVID-19 is rapidly evolving with respect to its pathophysiology, genetics,

transmissibility, clinical trajectory, immune response, optimum management strategies, and individual and public health approaches. This incomplete understanding of the disease limits the ability to prognosticate about its clinical course and therefore makes the application of ethical frameworks even more difficult. Front-line providers should not be expected to make rationing decisions in isolation, and therefore they must have guidance from clear, consistent, transparent, and uniformly applied ethical resource allocation strategies as well as triage officers and committees who have updated information about the availability of healthcare resources so that resource allocation strategies are not activated by hospital or health system leadership too early or too late. Now and in the future, intensive efforts to provide meaningful advance care planning must occur to ensure that patients' wishes are respected. Older adults would be well served by an intensive post-pandemic review of resource allocation strategies. As public health measures, creative use of resources, and shifting resources between states and communities become more commonplace, the need for rationing may be reduced or eliminated. When adequate resources are available, patient preferences for care remain the most appropriate metric and must be informed by a robust discussion of values, effectiveness, risks, and time horizon to benefit.

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